Appendix 14 ▪ Authorization for Use and Disclosure of Protected Health Information

Name of Client:		**MSSP #:**	

I hereby authorize the use and disclosure of protected health information about the above client for the purposes of use by MSSP as follows:

A. I authorize *[Name of MSSP site]* to make requested release or disclosure to: _____.

B. I authorize *[Name of MSSP site]* to receive and use my protected health information from: _____.

C. Description of client's protected health information to be used or disclosed:

Check all that apply:

☐ Physical injuries, illnesses or conditions

☐ Mental (psychological or psychiatric) illnesses or conditions

☐ Alcohol abuse and/or drug abuse

☐ Cash assistance, Medi-Cal benefits or other social and health services received

☐ Other (if checked, must describe):

D. Client's protected health information is being used or disclosed for the following purpose(s) by MSSP:

To determine the client's eligibility for MSSP, for their care management, for their health/psychosocial assessments, and for administrative purposes by staff.

I understand that I have the following rights with respect to this Authorization:

1. ***[Name of MSSP site]***, as the recipient of the protected health information may not further disclose the information unless ***[Name of MSSP site]*** obtains another authorization from me or unless the disclosure is permitted by law.

2. I may not be required to sign this Authorization as a condition to obtaining treatment (i.e., services) or payment or my eligibility for benefits.

3. ***[Name of MSSP site]*** will provide me with a copy of this Authorization.

4. I may revoke this Authorization at any time by mailing or personally delivering a signed, written notice of revocation to ***[Name of MSSP site].*** Such revocation will be effective upon receipt, except to the extent that ***[Name of MSSP site]*** has already taken action in reliance on this Authorization. Such revocation will remain in effect until I authorize, in writing, the release of the protected health information, except where the release of the protected health information is required or permitted by law.

5. I understand that this authorization will automatically expire two (2) years from the date of this authorization regardless of any other revocation I may request.

6. ***[Name of MSSP site]*** will not use or disclose the protected health information for marketing or receive compensation for the use or disclosure of my protected health information.

This Authorization will expire on ***[specific date]*** OR **2 (two) years from the date of signature.**

X		
Signature of Client or Client's Personal Representative	**Date**	**Relationship of Representative to Client**
Printed Name		**Date**
Address of Personal Representative		**Phone of Personal Rep**